



PATIENT INFORMATION

Legal Name: _____
Last First MI

Preferred Name (if different): _____

Date of Birth: ____ / ____ / ____ ☐ Female ☐ Male ☐ Non-Binary ☐ Prefer Not to Answer

Address: _____
Street City State Zip

Mobile Phone: _____ Home Phone: _____

Email Address: _____

Preferred Method of Communication:

☐ Patient Portal (My Health Online) ☐ Phone Call ☐ Text Message ☐ Email

May we leave detailed messages regarding test results or treatment information? ☐ Yes ☐ No

Emergency Contact: _____ Phone: _____

Primary Care Provider: _____ Occupation: _____

Preferred Pharmacy: _____

How did you hear about our practice?

☐ Physician Referral ☐ Google/Search Engine ☐ Insurance Directory ☐ Social Media

☐ Friend/Family _____ ☐ Other: _____

REASON FOR TODAY'S VISIT

What concerns would you like addressed today? Please check all that apply:

☐ Skin Cancer Screening ☐ Rash ☐ Acne ☐ Rosacea ☐ Cosmetic Consult

☐ New or Changing Mole ☐ Eczema ☐ Psoriasis ☐ Hair Loss ☐ Other: _____



DERMATOLOGY

CONSULTANTS OF SACRAMENTO

DERMATOLOGY MEDICAL HISTORY

Name: _____ Date of Birth: _____

SKIN CANCER HISTORY

Have **you** ever been diagnosed with:

- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Melanoma
- ☐ Atypical/Dysplastic Moles
- ☐ None of the Above

Has a **first degree relative** (mother, father, sibling, child) ever been diagnosed with **Melanoma**? ☐ No ☐ Yes

If yes, relationship: _____

SUN EXPOSURE HISTORY

- ☐ Frequent Sun Exposure
- ☐ Blistering Sunburns
- ☐ Indoor Tanning Bed Use
- ☐ Outdoor Occupation
- ☐ Daily Sunscreen Use

MEDICAL CONDITIONS

Check any that apply:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Asthma
- ☐ Thyroid Disease
- ☐ Autoimmune Disease
- ☐ Hepatitis B or C
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Bleeding Disorder
- ☐ Arthritis
- ☐ Cancer (other than skin cancer)
- ☐ Other: _____

SURGICAL HISTORY

Any surgeries or hospitalizations within the last 5 years?

- ☐ No
- ☐ Yes:

ALLERGIES

Medication Allergies:

CURRENT MEDICATIONS

Please list prescription medications, supplements, vitamins, and over-the-counter medications:

ADDITIONAL INFORMATION

Do you have any of the following?

- ☐ Pacemaker
- ☐ Artificial Joint
- ☐ Artificial Heart Valve
- ☐ Anesthesia Reaction
- ☐ History of Keloid Scarring

Additional information your provider should know: _____

Patient Signature: _____

Date: _____



PATIENT CONSENTS & FINANCIAL POLICY

COMMUNICATION CONSENT

I authorize Dermatology Consultants of Sacramento to communicate with me regarding appointments, billing matters, laboratory/pathology results, and routine medical information using the methods I selected on my registration form. I understand that text messages and email communications may not be fully secure and accept these methods for routine healthcare communications.

Initials _____

PROTECTED HEALTH INFORMATION RELEASE

I authorize Dermatology Consultants of Sacramento to communicate about my medical information with the following people: ☐ Self Only

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

HIPAA AUTHORIZATION

With my consent, Dermatology Consultants of Sacramento may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. I acknowledge receipt of the Notice of Privacy Practices and understand my rights regarding Protected Health Information.

Signature of Patient/Parent or Legal Guardian: _____

OPEN PAYMENTS DATABASE NOTICE

The Open Payments database is a federal tool used to track payments made by drug and device companies to physicians and teaching hospitals: <https://openpaymentsdata.cms.gov>.

I acknowledge receipt of this notice.

Signature of Patient/Parent or Legal Guardian: _____

Patient's Name: _____ Date: _____



FINANCIAL RESPONSIBILITY AGREEMENT

Insurance Coverage

As a courtesy, we will submit claims to your insurance carrier(s) when appropriate information is provided. Your insurance policy is a contract between you and your insurance company. It is your responsibility to understand your coverage, policy limitations, and to obtain referrals as required by your insurance company. Verification of benefits is not a guarantee of payment. Authorization, referral approval, or pre-certification does not guarantee coverage or payment. You are responsible for any copayments, coinsurance, deductibles, non-covered services, or other amounts determined by your insurance carrier to be patient responsibility. If your insurance information changes, it is your responsibility to notify our office before your appointment.

Initials _____

Patient Responsibility

Payment is due at the time of service for:

- Co-payments
- Cosmetic consultations/procedures
- Outstanding patient balances when applicable

Balances remaining after insurance processing are due upon receipt of your statement.

Initials _____

Pathology and Laboratory Services

Skin biopsies and certain laboratory tests may be processed by an independent pathology or laboratory provider. You may receive a separate bill directly from the pathology laboratory for these services.

Initials _____

Missed Appointment and Late Cancellation Policy

We respectfully request **at least one business day's notice** if you need to cancel or reschedule an appointment. Repeated missed appointments or late cancellations will result in dismissal from the practice.

Initials _____

Returned Checks & Collections

A \$25 fee will be charged for returned checks or failed electronic payments. If your account becomes significantly past due, reasonable collection efforts may be initiated. You agree to be responsible for costs permitted by applicable law associated with collection of unpaid balances.

Acknowledgment

I acknowledge that I have read and understand this Financial Responsibility Agreement. I understand that I am financially responsible for all charges not paid by my insurance carrier or other responsible party.

Signature of Patient/Parent or Legal Guardian: _____

Patient's Name: _____ Date: _____



MEDICARE PATIENT ACKNOWLEDGMENT

Assignment of Benefits

I authorize payment of Medicare benefits directly to Dermatology Consultants of Sacramento for services provided to me. I authorize the release of medical information necessary to process Medicare claims and related insurance claims.

Initials _____

Medicare Coverage

I understand that Medicare does not cover all medical services. I am responsible for:

- Annual deductibles
- Coinsurance amounts
- Services determined by Medicare to be non-covered or patient responsibility

Initials _____

Secondary Insurance

If I have supplemental or secondary insurance, the practice may submit claims as a courtesy when appropriate information is provided. I remain responsible for any balances not paid by Medicare or my secondary insurance carrier.

Initials _____

Advance Beneficiary Notices (ABN)

For services that Medicare may not cover, I understand that I may be asked to sign an Advance Beneficiary Notice (ABN) before treatment.

The ABN will explain:

- Why Medicare may deny payment
- Estimated costs
- My options regarding treatment

Signature of Patient: _____

Patient's Name: _____ Date: _____



Other options/wording/formatting.....

PHOTOGRAPHY CONSENT

Dermatology frequently uses clinical photography to document skin conditions and monitor treatment progress.

- ☐ I consent to medical photography for diagnosis and treatment.
☐ I decline medical photography.

Patient Initials: _____

FINANCIAL POLICY

I understand that:

- Copays, deductibles, and coinsurance are due at the time of service.
- Insurance authorization does not guarantee payment.
- I am responsible for charges determined by my insurance carrier to be patient responsibility.
- Cosmetic services are not covered by insurance and payment is due at the time of service.
- Biopsies and laboratory testing may result in separate charges from an outside pathology lab.
- Multiple missed appointments or late cancellations (within one business day) will be subject to dismissal from the practice.

Initials _____

Insurance Coverage

As a courtesy, we will submit claims to your insurance carrier(s) when appropriate information is provided. Please understand:

- Your insurance policy is a contract between you and your insurance company.
- It is your responsibility to understand your coverage, policy limitations, and to obtain referrals as required by your insurance company.
- Verification of benefits is not a guarantee of payment.
- Authorization, referral approval, or pre-certification does not guarantee coverage or payment.
- You are responsible for any copayments, coinsurance, deductibles, non-covered services, or other amounts determined by your insurance carrier to be patient responsibility.
- If your insurance information changes, it is your responsibility to notify our office before your appointment.